DEFINING MENTAL HEALTH NEEDS FOR BLACK PATIENTS WITH AIDS IN ALAMEDA COUNTY

Rita Hargrave, MD, Mindy Fullilove, MD, and Robert E. Fullilove, PhD
Oakland, California and New York, New York

This study examines the impact of race and psychiatric symptomatology on the treatment of black patients with acquired immunodeficiency syndrome (AIDS). The study consisted of two parts: 1) focused group discussions with AIDS health professionals, and 2) a retrospective chart review of 44 hospitalized AIDS patients. The group discussions revealed that there are specific gaps in mental health services for all AIDS patients and that psychiatric and medical services must be delivered in an ethnically sensitive manner to be effective with black patients. The chart review revealed no statistically significant difference between black and white patients in terms of prevalence of psychiatric symptoms. The results of this study suggest that ethnically sensitive psychiatric diagnosis and treatment may have important clinical implications in the long-term management of black patients with AIDS. (*J Natl Med Assoc.* 1991;83:801-804.)

From the Department of Psychiatry, Highland General Hospital, Oakland, California; and the HIV Center for Clinical and Behavioral Studies, Columbia University, New York, New York.
This work was supported in part by Center Grant #MH2459 from the National Institutes of Mental Health and Drug Abuse.
Requests for reprints should be addressed to Dr. Rita Hargrave, 1338 Leach, Oakland, CA 94602.

Key words • acquired immunodeficiency syndrome • blacks • mental health

Since 1981, many AIDS patients have been treated in California. Alameda County has the fourth largest number of AIDS patients of all California Counties.[1] Alameda County is a diverse, multi-ethnic community (42% white, 32% black, 11% Asian, 5% Native American, 5% Pacific Islander, and 5% other) with a large percentage of black AIDS patients. Black patients comprise roughly 25% of AIDS cases nationally but represent 39.8% of AIDS cases in Alameda County.[1]

In Alameda County, many low income black patients receive their medical care at Highland General Hospital (HGH), a public hospital serving indigent patients. Highland General Hospital is a 227-bed teaching hospital with over 11 000 admissions per year. Because of the multi-ethnic makeup of the medical staff and patients, HGH is uniquely suited for the study of the mental health needs of low income black and white AIDS patients.

Some descriptive studies have concluded that there is a difference between black and white patients in terms of help-seeking behaviors and perception of medical and psychological problems,[2,3] but this issue has not been examined among black AIDS patients. Recent large scale studies[4-7] have not commented on the prevalence of psychiatric symptoms among black AIDS patients. This study was undertaken to test the following hypotheses:

TABLE 1. HEALTH PROVIDER INTERVIEW QUESTIONS

1. What emotional or psychological problems of the AIDS patients you deal with are problematic to you?
2. What mental health service needs of patients and clinicians are currently met with existing mental health services?
3. If you were given $1 million for mental health services for which kinds of services would you spend it?

- that racial issues are a major factor in medical and psychiatric management problems of black AIDS patients,
- that black AIDS patients have a higher prevalence of psychiatric symptoms than white AIDS patients, and
- that psychiatric symptoms in black AIDS patients are less frequently recognized and treated compared to white patients.

METHODOLOGY

To evaluate the contribution of racial factors to the medical and psychiatric management problems of black AIDS patients, interviews were conducted with 18 health professionals from Alameda County AIDS clinics. The health professionals represented a diverse array of clinical disciplines (2 internists, 1 psychologist, 2 registered nurses, 4 licensed clinical social workers, 1 catholic priest, and 8 bachelor of arts level clinicians and administrators) and ethnic backgrounds (9 whites, 7 blacks, and 2 Hispanics). All of the health professionals were involved with direct patient care, however, the priest, the internists, and one of the bachelor's level health professionals also had extensive administrative program responsibilities. The informants participated in semi-structured group interviews. The first part was discussion in response to specific questions about the gaps in mental health services for AIDS patients (Table 1). The second part was less structured and focused on the clinical and administrative issues that have become obstacles in working with this population. The interviews were audiotaped and transcribed, and a content analysis was performed on the transcripts.

To assess if black patients have a higher prevalence of psychiatric symptoms than white patients and if symptoms are less frequently recognized and treated for black patients compared to white patients, a retrospective review was performed on the medical charts of all AIDS patients ($N=44$) hospitalized during the period of March 1988 to March 1989. The data compiled consisted of demographic information, discharge medical diagnosis, frequency of psychiatric consultation and DSM III-R psychiatric diagnosis when the patient was evaluated by the Consultation-Liaison Service (Table 2). The Brief Psychiatric Rating Scale was used as a post hoc measure of the frequency and nature of abnormal behaviors documented by the multiethnic nursing staff (48% white, 40% black, 10% Asian, and 2% other). The data were analyzed by an IBM 3090 using the Statistical Package for the Social Sciences (SPSSX). Descriptive statistics were calculated (means, standard deviations, and proportions) and the chi square statistics with Yates' correction was used to test differences between categorical variables. Differences between means were computed using one-way analysis of variance (ANOVA).

TABLE 2. DATA ON 44 AIDS PATIENTS HOSPITALIZED AT HIGHLAND HOSPITAL

	N	%
Sex		
Male	37	84.1
Female	7	15.9
Age		
0 to 19	0	0
23 to 39	35	79.5
40 to 59	9	20.5
60+	0	0
Race		
Black	27	61.4
White	13	29.5
Hispanic	4	10.0
Asian	0	0
Other	0	0
Sexual Orientation		
Heterosexual	14	31.8
Bisexual	11	25.0
Homosexual	19	43.2
History of Alcoholism	13	29.5
History of IVDA	10	22.7
History of Non-IVDA	7	15.9
History of Suicide Attempts	3	6.8
History of Prior Psychiatric Treatment		
Inpatient	4	9.1
Outpatient	2	4.5
Type Unknown	4	9.1
None	34	76.3

RESULTS OF INFORMANT INTERVIEWS

The majority of informants highlighted gaps in service delivery as an important issue for all AIDS patients. When queried about whether the current gaps in service posed any special problems for black

patients, the responses were divided. All informants agreed that services must be delivered in an ethnically sensitive and culturally relevant style to be effective with black patients.

Because many of the patients in this community use their family members as primary caregivers and sources of financial and emotional support, several key informants stated that special training in family therapy was essential to AIDS mental health service providers. Family therapy issues that service providers identified as critical areas were:

- family management of social stigma and social rejection associated with AIDS and related high risk behaviors;
- facilitation of psychological and physical reunion of the patient with his or her family; and
- management of family's bereavement and loss after the death of an AIDS patient.

Several key informants observed that the combined stigma of AIDS and mental illness, the inaccessibility of ethnically appropriate services and community resistance to mental health treatment contribute to underutilization of AIDS-related mental health services, noncompliance with treatment recommendations (both medical and psychological) and the denial of risk behaviors in minority communities. According to one informant within the black community, ambivalence toward mental health treatment in general and especially when associated with AIDS resulted in:

- continued high risk behavior (especially in terms of substance abuse);
- noncompliance with outpatient AIDS treatment recommendations:
- reluctance to accept AZT or other experimental therapies; and
- paranoia about the confidentiality of mental health services.

Providing effective mental health services for black AIDS patients may help to reduce noncompliance in other areas of mental health treatment. Though patient noncompliance and denial has long been recognized as a reality in urban outpatient clinics, there is a suggestion that among AIDS patients, the high clinic drop out rate may be partly the result of inadequate pre-test counseling. Neighbors et al observed the following among the black patients they interviewed:

> Income was not related to the decision to seek professional help. It is recognized that system variables also can have a profound impact on help-seeking behavior. In fact, there is evidence that structural barriers to professional help utilization are especially important for blacks. Black people may not perceive certain kinds of services as beneficial or effective dealing with their problems, or they may view certain types of professional services (eg, ministry) as congruent with black norms, beliefs, and lifestyles.[3]

These informants felt that the effectiveness of AIDS services to black AIDS patients could be improved by educating AIDS service providers about cultural issues in medical care and by increasing the number of black mental health professionals working in AIDS agencies.

RESULTS OF MEDICAL CHART REVIEW

Of the 44 medical charts reviewed, 37 patients were men and seven were women. There were 27 black patients, 13 white patients, and four Hispanic patients. There was no statistically significant difference between black and white patients in terms of the number of cognitive and behavioral symptoms documented by the nursing staff. Nineteen different psychiatric symptoms were identified, and the mean number of symptoms was 3.1. Results were obtained from general medical chart review and did not include a review of psychiatric charts. The most common psychiatric symptoms were anxiety ($n = 15$) and emotional withdrawal ($n = 11$). There was no statistically significant association between black and white patients in terms of the number of cognitive and behavioral symptoms documented by the nursing staff. However, there was a statistically significant association between the likelihood of psychiatric consultation and the numerical value of the BPRS score. Six percent of patients with low BPRS scores received psychiatric consultation while 50% of patients with high BPRS scores received psychiatric consultation ($P = .00001$).

DISCUSSION

The major findings of this study are: 1) racial issues are an important (but not overriding) factor in management problems of black AIDS patients; 2) there was no difference in prevalence of psychiatric symptoms or likelihood of psychiatric consultation for black AIDS patients when compared to white AIDS patients; and 3) there was a significantly higher likelihood for psychiatric consultation for patients with high BPRS scores as compared to patients with low BPRS scores.

Although this study did not detect differences in the level of psychological distress between black and white patients, cultural sensitivity as reflected in the style of service delivery does influence the effectiveness of

treatment interventions. Previous studies have linked the paucity of culturally relevant AIDS services to the ongoing resistance and ambivalence of black patients, their delayed entry into treatment and high rate of noncompliance with treatment recommendations.[2,3]

The fact that this study did not demonstrate any overt differences between black and white AIDS patients may be due to the methodological limitations of the study. Retrospective chart review is a post hoc and relatively inexact measurement of psychiatric symptomatology. The sample size, subject selection criterion, and limited duration of the study may have reduced our ability to detect differences in levels of psychological distress between black and white patients. Mental health workers and medical practitioners receive little formal training concerning the diagnosis and treatment of psychiatric disorders of black and other minority patients. Several studies suggest that black patients are at a greater risk than white patients of misdiagnosis of psychiatric disorders.[4,5] One study suggested that misdiagnosis among blacks was due to such factors as cultural differences in language and mannerisms, difficulties in the relationship between black patients and white clinicians, and the myth that black patients rarely suffer from affective disorders.[5] These researchers hypothesized that the underdiagnosis of bipolar disorder among black patients was due in part to the white clinicians' belief that hyperactive behavior is a part of normal black male aggressive behavior.[2] Another researcher suggested that black patients' emotional withdrawal and unwillingness to talk with white clinicians has been misinterpreted as resistance and in some cases, may represent depression.[2] It is quite possible that the mood disturbances and behavior difficulties associated with delirium and dementia may have been misinterpreted in black patients and has contributed to the underdiagnosis of organic mental disorders in black AIDS patients.

The finding that high BPRS scores resulted in a greater likelihood of psychiatric consultation suggests that the medical staff was aware of the association between behavioral symptoms and psychiatric disorders.[8,9] Still, it should be noted that although 50% of patients with high BPRS scores did not receive psychiatric consultations, the overall rate of psychiatric consultation (18.6) was relatively high when compared to other studies of AIDS patients.[10,11] Other researchers have noted an underutilization of psychiatric consultation, the inability of primary care physicians to identify psychiatric disorders in general, and the tendency to underdiagnose organic mental disorders in a general hospital population.[6,7] This is a disturbing situation because current studies demonstrate the high prevalence of neuropsychiatric disorders and the need for neuropsychiatric testing among AIDS patients.[8-12]

Because all the patients in this study were from the lower socioeconomic strata, the results may not be generalizable to working class or middle class black AIDS patients. Future studies should determine if the epidemiology of mental health needs of low income black patients is the same as compared to working class and middle class black AIDS patients. Future studies should address whether more aggressive, ethnically sensitive psychiatric interventions improve compliance and long-term prognosis of black AIDS patients.

Acknowledgments

The authors thank Frederick Derrick, RN and Gina Jones for their assistance with the manuscript.

Literature Cited

1. *AIDS Response Plan.* HIV/AIDS Services Division Alameda County Health Care Services Agency, 1989.

2. Mays VM, Cochran SD. Acquired immunodeficiency syndrome and black Americans: special psychosocial issues. *Public Health Rep.* 1987;102:224-231.

3. Neighbors HW, Jackson JS. The use of informal and formal help: four patterns of illness behavior in the black community. *Am J Community Psychol.* 1984;12:629-644.

4. Lawson WB. Racial and ethnic factors in psychiatric research. *Hosp Community Psychiatry.* 1986;37:50-54.

5. Jones BE, Gray BA. Problems in diagnosing schizophrenia and affective disorders among blacks. *Hosp Community Psychiatry.* 1986;37:61-66.

6. Steinberg L. An analysis of physician resistance to psychiatric consultation. *Arch Gen Psychiatry.* 1980;37:1007-1012.

7. Derogatis CR, Abeloff MD, McBeth CD. Cancer patients and their physicians in the perception of psychological symptoms. *Psychosomatics.* 1976;17:197-201.

8. Atkinson JH, Grant I, Kennedy C, Richman DD, Spector SA, McCutchan JA. Prevalence of psychiatric disorders among men infected with human immunodeficiency virus. *Arch Gen Psychiatry.* 1988;45:859-864.

9. Ostrow DG, Monjan A, Joseph J, Van Raden M, Fox R, Kingsley L, et al. HIV-related symptoms and psychological functioning in a cohort of homosexual men. *Am J Psychiatry.* 1989;146:737-742.

10. Dilley JW, Ochitill HN, Perl M, Volberding PA. Findings in psychiatric consultations with patients with Acquired Immune Deficiency Syndrome. *Am J Psychiatry.* 1985;142:82-86.

11. Perry SW, Tross S. Psychiatric problems of AIDS inpatients at the New York Hospital: preliminary report. *Public Health Rep.* 99:200-205.

12. Fernandez F, Holmes V, Levy J, Ruiz P. Consultation-liaison psychiatry and HIV-related disorders. *Hosp Community Psychiatry.* 1989;40:146-153.